Case Summary

LP is described by his family and friends as intelligent, mild mannered, gentle, caring, polite, witty, popular and good company. He had a close and caring relationship with his mother which became closer after the death of his father. LP held posts in accountancy and had to give these up due to work and exam pressures. He first experienced symptoms of becoming mentally unwell in 2009 and had episodic contact with both primary and secondary mental health services between 2009 and 2017.

On 6/2/2017, LP presented at NHS Hospital Accident & Emergency Department at 15:38 with mental health concerns. At 21:00 he was placed under Section 136 of the Mental Health Act by Police and at 23:59 was taken by ambulance to a 136 Suite in Wandsworth. After waiting outside in an ambulance for over three hours for a vacancy to arise, he was admitted to the unit on 07/02/17 at 03:33. A Mental Health Act Assessment was requested at 04:10 but was not undertaken due to both system and human errors. LP was transferred to the adjacent less secure unit on a step-down basis at approximately 09:30 and absconded from the unit at approximately 12:25. Following a Police pursuit on 08/02/17, LP was involved in a fatal car crash at 04:38.

Lessons

1. Lengthy ***waiting times*** for admission to 136 beds can increase people's crisis.

2. Changes have already been made to the ***risk assessment*** to include risk of absconding and the locking of the door in the less secure unit to avoid people leaving.

3. The importance of more ***seamless transfer*** between day and night AMHP services is key to reducing delays in Mental Health Assessments.

4. The mechanism for ***securing section 12 doctors*** was cumbersome. An improved system facilitating access on a 24-hour basis has been introduced.

5. Case by case consideration needs to be given to the need for both a ***section 42 and section 44 enquiry*** with a view taken on the impact on the family and what will be achieved.

Richmond and Wandsworth Safeguarding Adults Board

7-minute Learning Summary

Safeguarding Adults Review LP

136 bed capacity

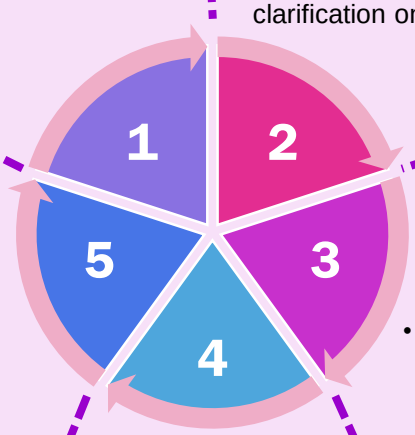
- The time spent by LP at NHS Hospital, followed by over three hours spent in an ambulance outside the 136 Suite awaiting a 136 bed, was clearly distressing to LP.
- The extensive waiting period also involved the utilisation of emergency services on prolonged escort duty.
- The arrival of a further patient awaiting admission to the 136 Suite was a factor in the decision to transfer LP to an adjacent unit on a step-down basis.
- Waiting times at the 136 Suite have been reduced and monitoring of admissions and escalation of clinical incidents is in place.

Risk assessment

- There has been a rising national concern about incidents of vulnerable adults absconding from mental health hospital units and of subsequent fatalities, with a common thread of shortcomings in risk assessment and a lack of urgency in responding to known risks.
- The decision to transfer LP to an unlocked unit did not give sufficient weight to the risk presented by a history of fluctuating mood, previous withdrawals from support and previous attempts at absconding.
- On transfer to the adjacent less secure unit, LP initially presented as calm, which may have been in part due to the less restrictive environment. Following the arrival of Police on the unit to enquire about a place in the 136 Suite for another patient, LP became agitated again and a decision was taken to arrange transfer back to the 136 Suite, which was full. He absconded while awaiting transfer.
- The risk assessment tool used by the Mental Health Trust did not include the risk of absconding and, for LP, was not signed by an appropriate level manager. This was not standard practice.
- Immediate action was taken following this incident, with locks put onto the exit doors on the unit, the inclusion of absconding in the assessment tool and clarification on level of staff to sign off changes.

Relevance of Section 42 enquiry when SAR agreed.

- At the time of LP's death a section 42 safeguarding enquiry was triggered and commenced. In parallel, a referral was made to the SAB for undertaking a SAR.
- There was discussion on halting the section 42 once the section 44 was agreed, however the family were reluctant for this to happen.
- The process of the section 42 was frustrating for LP's family as it did not and could not apportion blame.
- It is evident that the section 42 and section 44 processes essentially covered the same ground and caused LP's family some distress.
- In hindsight it may have been better to delay a decision on the section 42 until a decision was made in terms of the section 44 referral.



Stigma of Mental illness

- There is a strong social stigma and associated discrimination attached to mental illness, which can affect work opportunities and social inclusion.
- LP experienced a history of mental health concerns, dating back to 1999. He tended to initially engage with agencies but would later attempt to retract information and withdraw from services. He was very concerned about the potential impact of a Mental Health Act Assessment on his work opportunities, hence his reluctance to use services.
- Agencies completed thorough mental health assessments and considered LP's mental health needs to be low.
- Whilst agencies were largely reactive in responding to LP's presenting mental health needs, the scope for a proactive approach was limited by his tendency to withdraw from support offered.

Shortage of resources

- There was a shortage of available 136 beds when LP needed one. This is recognised as a national resource issue.
- A referral was made by staff in the 136 Suite for the Local Authority Out of Hours Approved Mental Health Practitioner (AMHP) service at 04:10 on 07/02/2017 for a Mental Health Act Assessment. Due to human and system errors this was not acted on promptly introducing delay in LP accessing the support he needed.
- There was a delay in communicating the clear result of the drug screening test to the AMHP service, until 06:15 that day.
- The decision was taken by the AMHP service to delay the assessment for completion by day services, due to the unavailability of a Section 12 doctor at this time was due to a gap in the availability of Section 12 doctors from 06:00 to 09:00. This has subsequently changed since by the introduction of a rota and a phone application, listing the availability of Section 12 doctors.
- The delay and ultimately the omission in conducting a Mental Health Act Assessment increased LP's anxiety.